IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF OHIO

EASTERN DIVISION

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EQUAL EMPLOYMENT OPPORTUNITY COMMISSION,	:	
PLAINTIFF,	:	
VS.	:	CASE NO. 2:13-CV-780
OHIOHEALTH CORPORATION d/b/a RIVERSIDE METHODIST HOSPITALS,	:	
DEFENDANT.	:	

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Deposition of DANIEL A. JONES, M.D., a Witness herein, called by the Defendant for examination under the applicable Rules of Civil Procedure, taken before Diane L. Schad, a Professional Reporter and Notary Public in and for the State of Ohio, taken pursuant to notice, at the offices of the Deponent, 1699 West Lane Avenue, Upper Arlington, Ohio 43221, commencing on Thursday, August 28, 2014, at 10:25 a.m.

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DEPOSITION OF DANIEL A. JONES, M.D.

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- - -

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- - -

Thursday Morning Session
August 28, 2014
10:25 a.m.

- - -

STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of DANIEL A. JONES, M.D., a Witness herein, called by the Defendant under the applicable Rules of Civil Procedure, may be taken at this time in stenotype by the Notary; that said deposition may thereafter be transcribed by the Notary out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; that the witness may sign the transcript of his deposition before a Notary other than the Notary taking his deposition; said deposition to have the same force and effect as though signed before the Notary taking it.

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DEPOSITION OF DANIEL A. JONES, M.D.

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DANIEL A. JONES, M.D.

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

EXAMINATION

BY MR. WHITCOMB:

Q Good morning, Dr. Jones. I'm David Whitcomb and with me is Lindsey D'Andrea. We're both lawyers who work at a law firm called BakerHostetler and we represent OhioHealth in a lawsuit that the EEOC has brought against OhioHealth on behalf of Laura Stone, who I understand is a patient of yours. Is that correct?

A That is correct.

Q Okay.

A Good morning.

Q Good morning.

So, just for the record can you state your name.

A My name is Daniel Jones, M.D.

Q Okay. And you've brought what appears to be a CV or resume of yours?

A Yes.

Q Can we mark this as Exhibit 1? Do you mind

if we mark these copies?

A Oh, that's fine. Yeah, they're yours.

(DEPOSITION EXHIBIT NO. 1 MARKED FOR IDENTIFICATION.)

Q I'm just placing in front of you what's been marked as Exhibit 1. Does this accurately identify your educational background?

A Yes, it does.

Q And your board certifications and licensures?

A Yes, it does.

Q And your position held?

A Correct.

Q Okay. Did you bring with you a file of Laura Stone's?

A I did not.

Q Okay. I just want to get an understanding of what documents you have with respect to Laura Stone. What would be in the file that you have on Laura Stone?

A Office notes.

Q Okay.

A Studies that were performed. And that's about it.

Now, we've switched over to electronic medical record; so there are certain things that are not there that weren't scanned, extraneous insurance

forms and whatnot that we chose not to scan into a document into her file, and so what you have is what the staff printed from her medical record.

Q Would you have correspondence with her primary care physician?

A That would be the office notes. All office notes are sent to the primary care doctor.

MR. WHITCOMB: We'll mark this as Exhibits 2 and 3.

(DEPOSITION EXHIBIT NOS. 2 AND 3 WERE MARKED FOR IDENTIFICATION.)

Q I'm going to show you two exhibits.

The first is marked as Exhibit 2 and it is two subpoenas that we had served on you. Do you recognize that document?

A Yes.

Q Okay. So the first page is a subpoena to testify at deposition and it asks you to bring medical records, but you did not bring -- you do not have your file with you?

A I don't have it in this room. I'm in my office so I could go get those documents.

Q We'll look at some documents and if it turns out there are additional documents other than what we

have, could you let me know?

And the purpose of showing you the subpoena is making sure we have everything.

A That's fine.

Q But the second subpoena which begins on the fourth page of this exhibit was a subpoena to produce all documents related to Laura Stone as set forth in the release?

A Correct.

Q And I'm showing you what's been marked as Exhibit 3 as well, and Exhibit 3 is 18 pages that was faxed to us by your office yesterday in response to our subpoena?

A Correct. That's what I'm told by my staff.

Q So you did not --

A Did I personally copy documents for you, no.

Q But this Exhibit 3 is not a complete set of the documents you have with respect to Ms. Stone, correct?

A That was printed from the electronic medical record.

Like I said, we did not copy her entire chart into the electronic medical record when we went through the scanning process of converting from paper chart to

electronic medical record.

Q So what is your understanding, if you have any, of what was produced to us in Exhibit 3?

A Progress notes and procedures performed, which primarily are what we scanned into electronic medical record documents.

Q Is this everything that's in your electronic medical records?

A I believe it is.

Q Okay. And she has a separate paper file?

A I don't know if we still have that.

Q Okay. Have you provided the EEOC with Ms. Stone's medical records?

A Everything that you have is everything we sent her is what my staff said.

Q Okay.

A So the same documents should be in both camps.

Q Okay.

A Because what she did was she took what she had printed off for this attorney, Keyana, and took that same pile and faxed it to you guys.

Q Okay.

A That's a printout from an electronic medical

record.

This is all -- Believe me, this is all new for every physician in the U.S., so my apologies for that.

Q And I'm not trying to cast blame or anything. I'm just trying to get an understanding, because we got different records from the EEOC or some different documents from the EEOC than we got from your office.

A I was not the guy at the copying machine.

Q Understand.

Okay. Do you know when you first began treating Ms. Stone?

A Approximately eight years ago.

Q And how did she become a patient of yours?

A She became a patient of mine after I believe leaving Neurological Associates, Dr. Arce, and seeking assistance with migraines, as well as observation regarding her seizures -- or her seizure.

Q Was she referred to you by a particular doctor?

A I don't recall.

(DEPOSITION EXHIBIT NO. 4 MARKED FOR IDENTIFICATION.)

Q I'm going to show you what I've had marked as Exhibit 4, and I will represent to you that these are

documents that we received from the EEOC that appear to be from your office.

A These are all my notes, uh-huh.

Q I thought it might be helpful for you to have them in front of you --

A Sure. Thank you.

Q -- when I was asking questions.

The first entry here is from May 17, 2006. It's the earliest document that we received. Is that your understanding of when you would have first seen Ms. Stone?

A Probably.

Q When a patient comes to you do you take a health history of the patient?

A I do.

Q What does that form look like?

A Oh, that's dictated. So what I do is I take notes on a piece of paper and then I dictate it into the -- I just dictate it. At that time I was dictating into a microcassette. I send that off to the transcriptionist and then I get back this type of document (indicating.)

Q Okay. If you look at --

A But those documents then are pitched. In

other words, my notes, my scribbles, once I dictated the case I pitch that. I shred it.

Q Does the health history -- Is a document created that has the health history?

A Well, I'm a specialist so it's a neurological history that I've obtained.

It's not, for instance, a document that an internist or a family practitioner might dictate; it's a neurologically-focused consultation. So I'm not sure what you're asking. Maybe --

Q Well, my problem is, we've been having difficulty obtaining a complete set of your records, so I don't know what I have and I don't have.

MS. LAWS: Objection.

THE WITNESS: I don't know what you're asking. When you say do I obtain a health history, what you're seeing or what you presented to me today are my dictations. So when I obtain a history from a patient, I take that information and I put it into a document form and that serves as my encounter.

BY MR. WHITCOMB:

Q Are you able to get your file since we're in your office and we have subpoenaed it?

A This is what I have from the staff that has

been scanned into the electronic medical record. I can go get my computer. That's what we have.

Q Just to walk through these documents that we have in front of you as Exhibit 4. When she came to you in 2006 the issue that she was seeking treatment for was what?

A I believe it was migraine.

She had brought me a disk and said can you review this disk for me and give me an opinion on it. So this letter just represents, you know, I've reviewed the scan of your brain and there is a small stroke there.

So this is just a courtesy that I don't bill the patient for. I say if you have any scans I'll take them, I'll review them for you and I'll render an opinion. Another set of eyes looking at that film. And that's something I do for every single patient.

If a patient has a history of stroke or brain tumor or a concussion -- A radiologist is one set of eyes. Well, they're not always correct, so I always tell the patient when they walk through the door, bring your CD. I'll take a look at it. If I can offer you any opinion that's different, if I can identify something else that somebody missed, that's another set

of eyes. That's good for the patient.

Q What's on the CD?

A This was an MRI of the brain.

Q If you flip to the next document, the note dated September 12th, 2006.

A Yeah.

Q I notice in the clinical background it says, "She denies any excessive daytime sleepiness" at the last line?

A Uh-huh.

Q Is there a reason that you would have been talking to her at that time about whether she had excessive daytime sleepiness?

A I'm a sleep specialist so that's part of the questions, yeah.

Q I just want to make sure we walk through these in order.

The next document is a note from October 10th, and then the next one is a note from October 29th, correct?

A November 29th.

Q I'm sorry.

A Yeah. I see those. Those are mine.

Q Okay. And then the next note appears to be a

note of yours from January 3rd, 2007, correct?

A That's correct.

Q And in the Impressions you noted in the fifth line down that, "She is sleeping eight to ten hours each night." Do you see that?

A I do.

Q And, again, is that something you would ask her because you're a sleep specialist and you're interested in her sleep patterns?

A No. From a standpoint of seizure we have to make sure that our patients are getting enough sleep because one of the triggers of seizure is sleep depravation.

Q So this note is from January 3rd, 2007, and if you flip to the next page it's the next note that I have from your office which is -- and if you want to take the clip off, that's fine. It's just to keep them in order.

A All right.

Q So the next note I have appears to be a note from your office of June 10th, 2009?

A That's correct.

Yeah, I changed format. At this point with an Excel document I was just typing everything in, so I

quit the transcription thing.

Q Did you see Ms. Stone between January 3rd, 2007 and June 10th, 2009?

A I don't believe I did.

Q Okay. Do you know why she came to your office on June 10th, 2009?

A She was still having headaches. So I don't know if she had gone to see someone else in the interim or not.

Q On this note I see at the top there's a column for R.O.S.

A Review of systems, correct.

Q And what is a review of systems?

A Those are questions that I might ask the patient outside of the typical questions for the problem that they came in. So it could be a scattered group of questions I might ask regarding cardiovascular, respiratory, g.i., bowel or bladder.

Typically if it's problem-focused I'll just stick to things that might be affecting her complaint as she comes in.

Q The first entry says, "Sleep is poor." Do you recall anything about her conversation with you?

A I do not. But that's part of my questioning

for headaches. So if an individual comes in and they say I'm having headaches, then there's a certain number of triggers that we go through that might contribute to a headache syndrome.

Q The second entry says, "Work and school." Do you know what that refers to?

A She listed problems that would be contributing to an issue with poor sleep.

Q And when you say, "she listed them," she listed them in, what, verbally or --

A Yeah, verbally. She would say work and school are contributing to my poor sleep.

Q Do you remember anything about what her work was?

A As pertaining to this document I don't see that I wrote anything regarding that other than she was only getting four hours of sleep per night.

Q Did she explain why she was only getting four hours of sleep per night?

A She was studying and then she had to go to work, yeah. So in her 24 hours a day of activity, work and school were taking up large chunks of time.

Q Under four hours per night it says, "Hypersomnia 8/10"?

A Eight out of ten severity.
Q What does that mean?
A Well, back then -- and currently we use an Epworth scale. But back then I would say on a scale of one to ten how sleepy are you. Ten is the worst sleepiness you've ever experienced. So she listed that as an eight out of ten.
There is no meter on her head that says this is how sleepy I am, so I can't read that. I just ask patients how sleepy are you and they give me a number.
Q And on the left side where it has severity it has six to seven out of ten. What does that refer to?
A Her headaches.
Q Okay.
A Yeah. Headache pain is a six to seven on a sale of one to ten.
Q Gotch you.
And then at the bottom of the form you have Impressions and can you explain what Impression No. 4 is.
A Hypersomnia, which means excessive daytime sleepiness.
So it's a general term. Rather than writing excessive daytime sleepiness, you know, sort of letter

economy, I just wrote hypersomnia. "Rule out apnea and narcolepsy."

Q Is there any testing to get the impression of hypersomnia or is that based upon her self-reporting?

A Oh, no, there's plenty of testing for that.

And, in fact, over in Plan I listed polysomnogram, which is a sleep disorder, with MLST, which is a Multiple Sleep Latency Test where we test the individual with a few naps after they've had a sleep study the night before.

Q Okay. I understand that. But at least when you wrote this impression that was before testing?

A That's correct.

Q Okay.

A Yeah.

Q The next page where it says D.O.S. at the top left hand --

A Oh, Date of Service.

Q Yea. So this is also 6/10/09, correct?

A Correct.

Q So in that first box it says, "Slept poorly in the sleep lab due to cold temps but diagnosis made of UARS." Can you explain that to me.

A I'm wondering -- and I didn't notice that

before, but I'm wondering if that -- because I have to type in the date of service every time and when I open up an old document on a patient or the previous visits document I need to type in the new date of service. So this is -- this is obviously a time after she had her sleep study 7/2/09.

Q So is it your understanding that the 6/10/09 would not accurately reflect the date of service of this record?

A Yes. This would have to be immediately after her sleep study.

Q Okay.

A And it could have been the morning of. I'm not sure.

Q Okay. I'm just trying to determine so we can follow along.

A These are triplicate.

Q I know, but we produced everything to you that the EEOC produced to us and we got triplicates from them. So you are going to have to keep them in order because otherwise we'll get off-track.

A Sorry.

Q That's okay. I should have explained that at the beginning.

A My bad. I apologize.

Q So do you see the entry I'm looking where it says, "Slept poorly in the sleep lab due to cold temps but diagnosis is made of UARS"?

A Correct.

Q Can you explain that to me.

A Yeah. Sometimes and regardless of the lab I've had patients come back to me after sleeping at lab X, Y and Z and say, well, the techs were talking, I couldn't sleep.

In this situation she was sleeping here and she apparently told the technician that it was a cold room, and I took note of that.

Her sleep was somewhat disruptive from respiratory arousals, so I ran with -- at that point in time I ran with upper airway resistance syndrome as a potential cause of her sleepiness.

Q And what is upper airway -- I'm sorry, is it upper airway resistance syndrome?

A That's correct.

Q Okay. What is that condition?

A This is sleep disorder breathing that is in between snoring and obstructive sleep apnea.

So this is a -- and it can be just as

incapacitating as obstructive sleep apnea as far as its impact on the individual's wakefulness.

So upper airway resistance syndrome refers to a patient's response to some type of disruption of air moving through the -- between the point of the lips and the trachea.

So there's some issue with movement and as the patient inspires or takes a deep breath while they're sleeping there is a disruption of the sleep that triggers the brain to alertness.

So that triggering of alertness causes them to then have a disruption of the stage of sleep they're in and it might actually cause them to wake up, particularly what we call microarousals. And microarousals over and over again throughout the night disrupt the pattern of sleep, disrupts the depth of sleep and it causes the person to have excessive daytime sleepiness.

Did I explain that well?

Q Yes.

A Okay.

Q In the Impression section of this document you indicate a follow-up with Dr. Koelling. Did I say that right?

A Yeah. That's an optometrist or ophthalmologist. She had seen that individual.

I couldn't see her fundus at the previous exam very well. She was going to follow up with that individual.

These are notes to myself to make sure that I'm keeping track of her eye problem even though it's really not my primary problem, because it can affect headaches.

Q On this document then there's a plan and what the plan for? Is that a plan to treat the UARS?

A That's correct, yes.

So the primary approach to upper airway resistance syndrome we try to approach that without using any pressure treatment or CPAP. So putting gravity to work for the patient we ask them to elevate the head of their bed typically with a couple of two by fours or a brick or something, and I explain that to the patient at the time.

But elevating the head two to four inches allows the tissues of the neck to be on the incline and that can reduce the breathing problem. Then I also add Flonase nasal spray, which opens up the pipes. It decreases swelling of the nasal mucosa. You get a

better flow of air. So sometimes that's enough to resolve the breathing issue.

Q And there is an entry under Plan that says, "Keep same sleep hours." Can you explain that to me.

A Yeah. The explanation that I actually have with the patient that refers to that topic is with regard to sleep hygiene. So I'll go through and I'll describe please keep the same bedtime, the same waking time if you possibly can. That would reduce the impact of some type of diurnal cycle issue in maintaining wakefulness.

Q And for treatment of UARS does it matter whether the patient, the individual, is sleeping a normal schedule during the day or sleeping a normal schedule at night?

A No.

Q As long it's a normal schedule it's --

A No. I'm just asking her to obtain sleep hygiene in this situation just to make sure that her sleep, the efficiency of her sleep is as good as it can be.

Q Okay. And just turning back to the previous page, and they have numbers in the bottom right-hand corner.

A Yeah.
Q 362.
A 362, yeah. Got it.
Q You had indicated that you wanted to rule out apnea and narcolepsy?
A Yes. Common things are common, so those would be common causes of hypersomnia.
Q And how do you rule those out?
A Well, the obstructive sleep apnea we ruled out with a baseline study. That was the sleep study that I'm sure you'll show me later on here.
So her apnea hyponea index was 4.7, which falls below 5.
5 is the acceptable cut-off for a normal human being over the age of 16. So we basically ruled out obstructive sleep apnea.
The diagnosis of narcolepsy we like to do a multiple sleep latency test to rule out.
Clinically if you look at the sleep medicine criteria from the American Academy of Sleep Medicine, you could either rule it out, you can approach the patient from a clinical standpoint, or you can throw in the testing, or you can do a spinal tap and get a CSF hypocretin level. There are a number of ways you can

approach the diagnosis of narcolepsy.

Q And so for Ms. Stone what did you do?

A I believe we did an MSLT in her case.

Okay. So that was from 8/6/09. Typically we do them the day after, but in this situation, probably a scheduling issue, we ended up doing that about a month later.

Q Okay. So we'll get to that record. I want to continue to go chronologically because it's easiest for me.

A Sure.

Q So just turning to page 7 and 8. Page 8 appears to be a duplicate.

I'm sorry. 740 appears to be a duplicate. So then --

A Okay.

Q So I'm up to page 365 and this appears to be -- can you explain what this is because it looks like some type of typewritten --

A Oh, this is actually a technician note.

The technicians who performed the sleep studies will go through -- at the end of the study they'll give their paragraph description of how the night went and what they observed.

Q What is a baseline PSG?

A A baseline basically defines whether the sleep study is performed as an initial study or whether it's performed as a follow-up study or as a study associated with CPAP titration. So typically we'll describe baseline versus CPAP titration study.

Basically, it means there is no oxygen given and no CPAP given for that study. Sorry about that.

Q Thank you.

So are the patients told whether they should sleep before coming in or not?

A Yeah, they're asked -- they're just asked to do their regular routine the day before a sleep study but to present to the office at 8:00 or so. That's the drill or the routine for that.

Q And where this note says, "Her sleep is stable with delta wave sleep present," what does that mean?

A The technician has looked through the sleep study and he is stating that slow wave sleep, which is N3, is present and stable. In other words, there wasn't a lot of disruption in his or her opinion -- let me see who did this one -- okay, her opinion that that delta sleep was very disruptive.

Q Then it says, "Her REM onset latency is a little quick but within normal limits." What does that mean?

A She's just describing -- again, this is another individual's verbiage, and I do take this into account as I look through a study, but I don't base any interpretation on the notes of a technician.

So just I want to say that this is not my document. It's in my chart but this is a technician note.

So her description she's just saying she thought that the REM sleep came on quickly but she felt it was within normal limits.

Q Okay. And where it says, "Her EKG remained without" --

A "Ectopy."

Q "Ectopy," thank you, what does that mean?

A Ectopy is extra heartbeat. PVCs, PACs, PJCs.

Q So in terms of reading this note is there anything unusual about her sleep that would cause you concern by reading the note?

A Well, I mean, any time an individual is experiencing apnea or fragmentation of sleep then I would say that's an issue, yeah.

So, remember, she does have 4.7 apneas per hour, so she is having -- she is experiencing apneas. It just doesn't qualify her for an aggressive management with CPAP.

Q Is there anything in this note that reflects or would help diagnose narcolepsy?

A Well, the REM interval that seems to be a little quick in onset, you know, that might be helpful.

Q So moving on I'm going to skip 366.

A These are all technician notes, by the way.

Q Okay. And I will skip 367.

A 368 is a hypnogram. It's a description of the architecture of the patient's night.

Q Okay. We'll skip that. And then I'm going to skip 369. I think that get us to 370, and there's a handwritten note on 370?

A Correct.

Q Is that your writing?

A That is.

Q Okay. And so what does that say?

A Those are just quick notes to myself that the patient is exhibiting certain problems with their sleep diagnoses related to -- that I felt were uncovered by this sleep study.

Q And what are the diagnoses that you thought were uncovered by this sleep study?

A So Upper Airway Resistance Syndrome is the URAS, and RBD is REM Behavior Disorder, which are paradoxical which means they shouldn't really be there but they're their movements during dream sleep.

So REM sleep equals dream sleep. Typically during dream sleep we are paralyzed. In this case during dream sleep -- and you can see this on the hypnogram on 368 and the hypnogram where it shows limb movements. The large hatches across the top are dream sleep intervals where it says REM cycles. So there are three of those. And during those REM cycles if you then follow the vertical down, you'd find that she has limb movements during those intervals.

Typically, all limb movements stop during dream sleep. And so that displays paradoxical or it shouldn't be there type of jerky movements of her extremities during REM sleep.

Q The next page then is 371.

A Okay.

Q And this appears to be a note that's from July 2nd, 2009. Is that accurate?

A Correct.

Q So your impressions then are the two diagnoses that you indicated, the UARS and the mild REM behavior disorder?

A Correct.

Q So at this point am I correct that you did not or had not diagnosed narcolepsy?

A That's correct.

Q Had you ruled out narcolepsy yet?

A No.

Q So what is the plan -- is that first bullet point is that some sort of medication?

A Yeah. Amitriptyline was what she was taking as a prophylactic against migraine headaches and so I thought I'm going to continue that.

When we treat Upper Airway Resistance Syndrome, because of the different arousals that are present during that disorder, Amitriptyline or Trazodone can be used in that scenario, so I said continue Amitriptyline.

The bullet point elevate head of bed three to four inches and the steroid nasal spray we already talked about.

Q So the next page is 776 and it appears to be a duplicate?

A That's true.
Q 777 is the next page and it appears to be a duplicate?
A Correct.
Q 778 I'm going to skip. It may be a duplicate.
779 I'm going to skip.
780 I will skip.
781 I will skip.
782 it's a duplicate and I will skip it.
742 is a duplicate.
743 is a duplicate.
That brings us up to 744.
A Okay.
Q So what is this document?
A These are, again, technician -- This is a note that is generated by a technical review, what we call scoring.
So when a technician looks at a sleep study, at the end of the night they have to count the number of arousals, the number of apneas, the number of awakenings, the number of limb movements and whatnot and they tally all of those scores. So this is in some ways a tally sheet.

Q Okay. And this was the tests that were run?
A This is the baseline sleep study.
Q Okay. So let's go ahead and then skip down to 786.
A Uh-huh. I'm there.
Q Okay. Perfect.
So this appears to be the next time you saw Ms. Stone?
A That's correct.
Q And this is on July 17, 2009?
A Correct.
Q Okay. So I paused because it looked very familiar to me. And this appears to be the same document that -- or similar to a document we looked at earlier, which was 787 that had the date of service of 6/10/09?
A Right.
Q But is this the accurate date of -- it would have been July 17, '09?
A Correct.
Q Okay.
A Yeah. We really didn't change anything that visit.
Q Okay. So because you had indicated you

thought that this document, 787, just had the wrong date of service on it?

A No. No. That was another document that you showed me. That was the 6/10/09 type of thing. Yeah.

No, this is 7/17/09, so this is correctly dated.

Q I understand. But if you look back at page 787, do you have it there?

A Yes.

Q Is this the same document, it just has a different date of service?

A Oh, okay, good. Yeah.

So this is that document, the mystery document from before where I had dated it 6/10/09, and then in reviewing I had changed the date on it.

Q Right.

A All right. So the document where -- the mystery document was actually the 7/17 visit.

Q Okay. So your plan then on July 17 or a part of the plan was for her to keep the same sleep hours as we discussed earlier?

A That's correct.

Q Okay. So the next page, which is 363, indicates a date of service of August 6, 2009?

A Correct.
Q So what was happening on August 6, 2008?
A So this was her multiple sleep latency test.
Q And if you turn to page 364, are these your notes from August 6, 2009 then?
A That's correct.
Q And I see under the Impression it says, "Probable etiology." Did I say that right?
A Yeah, right, cause. Probable etiology or cause.
Q "Narcolepsy versus upper airway resistance syndrome." Can you explain that to me.
A Yeah. So whenever we do a multiple sleep latency test we hope that we'll get a textbook answer. And so in this case she had one sleep onset REM period in nap number two under data at 10.5 minutes and she had a mean sleep latency of 6.9 minutes, which is abnormal.

Anything below nine minutes is indicative of objective evidence of excessive daytime sleepiness.

So because I had already identified a problem with her breathing at night and upper airway resistance syndrome can cause excessive daytime sleepiness, and because there weren't two naps, which is typically what

we like to see with narcolepsy, although we don't always see that, but because at least one nap was present but not two I said it's still open. It could be narcolepsy, it could be upper airway resistance syndrome.

Q And explain one nap versus two naps.

A Sure. So the criteria for absolute diagnosis of narcolepsy is clinical history that's supportive, excessive daytime sleepiness, sleep paralysis, hypnagogic hallucinations, cataplexy.

I can explain all of those if you want me to but they're available in every textbook.

So if we have one nap where the patient experiences during that nap -- and typically the naps are 20 minutes. If the patient experiences an occurrence of REM sleep then that's considered abnormal in the right clinical setting.

If two naps are present where REM sleep occurs -- because the typical REM onset is somewhere over 45 minutes, so if you're just studying a patient for 20 minutes and, boom, they're into REM sleep, you have to ask the question, okay, maybe this is narcolepsy.

But could it be delayed sleep phase disorder,

yeah. Could it just be just real crummy sleep, obstructive sleep apnea or upper airway resistance syndrome, you know, not as common but maybe.

But because of the patient is in this situation with one nap versus two naps, which is what we want for absolute criteria to meet that, I had to list the differential or the list of possibilities for her sleepiness as narcolepsy versus upper airway resistance syndrome.

Q And when she's taking this test does she have multiple naps?

A She does. Five total.

Yeah, let me explain that multiple sleep latency test.

So the patient presents. They're asked to go to sleep at about 7 a.m. They are in the bed with lights out for 20 minutes. That's nap number one. Then they're awake for two hours and they're asked then, lights out, go to sleep or get in bed and try to sleep if you can. That nap goes 20 minutes and then so on throughout the day.

This is a daytime study versus the baseline sleep study which was the all-night study.

So in a multiple sleep latency test these

individual naps then are studied to see, number one, if the patient can fall asleep. And if they fall asleep below nine minutes that's pathological. That means they're excessively tired.

And the second thing is do they experience dream sleep during that 20-minute nap. And if they do, because REM sleep shouldn't come on that quickly, it should come on over that 45-minute interval, then that's considered pathological.

Q Okay. So what is narcolepsy?

A It's a neurological condition. It can be primary or secondary. It can be a disorder that a patient is born with. It can also be caused by stroke, by metabolic disturbance. It can be caused by head injury.

A lot of military guys are coming home and they're being diagnosed with objective clinical criteria that are consistent with a diagnosis of narcolepsy, even though it's not something they were born with.

But narcolepsy it's a sleep-wake disturbance where patients are really never awake and they're really not getting good sleep either. So they have problems with maintaining daytime wakefulness and their

days can be -- you can have sleep intrusions throughout the day. You can have cataplectic episodes where the patients just lose all muscle tone. That's REM sleep, that form of sleep where we're supposed to be paralyzed like I discussed earlier.

That sleep paralysis can occur during the daytime as an intrusion to alertness and that causes collapse. Even though they don't fall asleep, they're awake, they're breathing, they're looking around the room, but they can't move. They slur their speech. So that's cataplexy.

They can experience sleep paralysis where they wake up during the night and they're looking around the room but they're still stuck sort of in dream sleep so their body is still paralyzed. So they're laying there. They can't move their muscles until they become fully awake. So that can be very frightening.

And then hypnagogic or hypnopompic hallucinations can occur where when you're going to sleep you're in between dream and wakefulness and you can have hallucinations where you become confused, wait, am I dreaming this or is this really happening. And that can happen when you're going to sleep,

hypnagogic hallucinations, or when you're waking up, which is hypnopompic hallucinations.

Q Okay. And aside from the evidence of the REM sleep during one nap was there any indication in this test that Ms. Stone was exhibiting any of those symptoms of narcolepsy?

A We don't -- Yeah, we didn't describe -- that's a good idea, though. We could have a questionnaire. We don't describe sleep paralysis, hypnagogic hallucinations, cataplexy, the hypersomnia as part of this technical study. It's just a study to observe brain activity.

So, yeah, that would not be included in this document.

Q Okay. And do the technicians record that anywhere if they observe those symptoms?

A Well, cataplexy really wouldn't play into this because the patient is supine. They're laying there in bed. So that really would not be something we're concerned about.

Hypnagogic hallucinations, if the patient has a panic attack because of either sleep paralysis, which they can, or with hypnagogic hallucinations, that would be something that would be recorded in the technical

notes.

And then the hypersomnia is the reason why the patient is there in the first place, so that would be recorded.

Q If a patient only had one nap revealing evidence of REM sleep, does that give you any -- if this is narcolepsy does that give you any clue as to whether it's a mild form of narcolepsy or a severe form of narcolepsy?

A Well, the confounding factor in this case, unfortunately, is that it's a dirty study. And that might raise an eyebrow in the legal community but all it means is that the patient was not -- the patient was taking a medication and that medication is Amitriptyline.

Unfortunately, Amitriptyline can delay -- Fortunately and unfortunately; it's doing what it's supposed to do, but it can delay sleep onset REM.

So that you could do a multiple sleep latency test. It will run 20 minutes and the patient won't experience sleep onset REM because they're on a tricyclic anti-depressant.

So the patient was taking 25 milligrams of Elavil or Amitriptyline every night. So in the best or

in a perfect world we could just stop medication abruptly and study a patient with this type of testing. Unfortunately, I would have run the risk of having her had severe migraines, not doing well physiologically if I had done that, so I chose to just go ahead and run the test to try and quantify her sleepiness. But that may -- that likely contributed to the false negativity of this test.

Q What do you mean the false negativity?

A Well, in other words, if she hadn't been on Elavil she may have gone into REM sleep every single nap. I just don't know that.

Q Okay.

A So what I'm saying is, she's on the medication that delays REM sleep. I only got one nap with REM sleep. Without Elavil on board I might have gotten five. I won't be able to answer that question unless I perform a multiple sleep latency on her on no medication.

Q And in the plan what is stimulant treatment?

A The stimulants that we use for excessive daytime sleepiness are primarily amphetamines, Adderall, Ritalin, a lot of things that you hear about in the news for ADD, ADHD. We also use

species-specific medications such as Modafinil, Nuvigil.

Modafinil at this point in time which was created specifically for narcolepsy.

Q And --

A Or oxybate.

Sodium oxybate is the medication that we use specifically for narcolepsy.

Q And is the medication successful in treating narcolepsy?

A Not always.

Q And then the second bullet says, "Consider brief daytime naps."

A Right. We call these power naps. So individuals will take a 10 to 15 or 15-to 20-minute nap throughout the day if possible. They don't always have that luxury.

But if they are able to do a 15-to 20-minute nap at various intervals throughout the day sometimes provides an ability to become alert, although it's typically brief in duration, that alerting mechanism.

Q And then the third bullet is, "Consider oxybate nightly." What is that?

A Sodium oxybate acts by increasing neurotransmitters in the brain that are deficient in narcolepsy, and so it is considered the drug of choice for narcoleptics.

Q Is this plan a plan of treatment for narcolepsy?

A That would be considered good advice for a narcoleptic, yeah. Yeah, those would be primary considerations.

Q Okay. Is this a typical treatment plan for narcolepsy?

A Yes.

Q And I see in this plan there's nothing about sleep schedule; is that correct?

A Well, the sleep hygiene I've been letting her know all along.

The fact that didn't make this list does not mean that we wouldn't be paying attention to sleep hygiene, because I tend to focus on that all along with the patient as the notes show that we're talking about sleep efficiency.

Q When you're talking about sleep hygiene you're talking about maintaining a regular sleep schedule?

A That's correct.

Q And as you said earlier, it doesn't matter when that sleep schedule is as long as it's regular?

MS. LAWS: Objection.

THE WITNESS: Well -- Okay. With regard to sleep efficiency, if a patient is keeping regular hours, typically we can get someone through life having them keep regular hours as long as they have -- for instance, if someone's -- if someone is in a normal -- and I know this case is about shifts. So if you and I who are first shifters if we are getting up and going to work every day and we work 9:00 to 5:00, 8:00 to 4:00, whatever the situation is, if we can maintain nighttime hours that are reasonable, say, 10:00 to 6:00, 10:00 to 7:00 sleep hours, that would be considered efficient sleep maintenance.

If an individual is working second shift, 11:00 to 7:00, all right, they're getting to bed hopefully between 8:00 and 9:00, they can still maintain nighttime hours.

And the reason why I emphasize nighttime hours because the sun is what controls your diurnal cycles, and your ability to maintain alertness depends on how well you can follow the day.

The sun coming up, the sun going down that's what adenosine is following, which is a neurotransmitter that brings on sleepiness. That's what melatonin spikes in your brain. We all have melatonin in our brain. That's what melatonin follows. And those are all factors that send us into sleep.

So for us to maintain efficient sleep we have to try and follow a diurnal cycle that closely approximates the sun.

So if we're able to do that, great. If we're not -- say I'm cursed and I've got to work 11:00 to 7:00, well, then what I'm doing is at 8:00 when the sun is coming up I'm trying to go to sleep.

So if I'm not getting to sleep in a very dark room then my brain is going to start getting wonky and I won't be able to follow a real nice diurnal cycle so that my adenosine and my melatonin -- all the neurotransmitters in my brain can't fall into place to put me into deep restorative sleep.

Stop me any time just to explain. But what I want to drill home here is that for me to have efficient sleep I've got to have a light/dark cycle that approximates the normal day with sunshine and darkness. And if I can't do that, if I don't have a

dimly lit room, if I don't have room darkening shades, then the neurotransmitters in my brain that are supposed to establish efficient sleep don't function well.

Q Are there individuals who suffer from narcolepsy who are able to maintain sleep hygiene as you indicated even though they work the third shift?

A Well, the factor of narcolepsy brings in another problem because narcoleptics rarely sleep well, especially if they have experienced sleep paralysis in the past, especially if they have experienced hypnagogic hallucinations. Because that creates an anxiety. That creates to a degree an anxiety disorder where sleep does not come easily to them.

So if you bring in the factor of narcolepsy to this, yes, they could maintain all of those things with room darkening shades and whatnot, but narcoleptics rarely have really good sleep.

Even in the most wonderful situation, you know, even if you're living on an island somewhere and you have no responsibilities whatsoever, as a narcoleptic you can still have crummy sleep.

Q Do you recall having any conversations with Ms. Stone in terms of whether she was able to maintain

a regular sleep schedule while working the third shift?

A Well, and what I -- earlier in the notes I think I described it. She was -- you know, I wasn't in her house so I don't know, but from the questions she was having trouble maintaining good sleep hygiene because of work and sleep -- or work and school. Excuse me. Yeah.

So she was going to school and working and because of all of those responsibilities I think that her sleep was less than efficient. Her sleep hygiene wasn't the greatest.

Q So was it your understanding she was working at nights and trying to go to school during the day?

A I don't know what time of day she was going to school. I don't know if it was mornings or afternoons or whenever, but it was a combination of work and school that was chewing away at parts of her 24-hour day.

Q And would she have been able to maintain a better sleep pattern if she was not going to school in your opinion?

A Well, the pattern of sleep, yeah.

Well, no, your question is direct so the answer is yes, because if she didn't have school

responsibilities, then that would offer her a larger block of the 24-hour day to maintain I would assume a better sleep interval.

Q So we're at 364, and then I'm going to skip -- the next page is a duplicate.

I'll skip the next page 747.

I'll skip the next page is a duplicate 750.

I'll skip 751.

That brings me up to 725. Is that where you're at?

A Yes.

Q So this looks to be a date of service of September 18, 2009; is that correct?

A Correct.

Q Okay. This would be the next time you saw her after August 6th?

A I believe so.

Q Okay. So under R.O.S. there's a box that's blacked out. Do you know why that's blacked out?

A I don't know. I don't -- I have no idea. But it was scanned into the computer that way.

Q Is that something that's blacked on your end or is that something that the EEOC blacked out, if you know?

A I'm assuming it's me because it's within the Excel spaces there. And it was scanned. I can pull it up on the computer.

MS. LAWS: Actually, looking at the document I'll represent to you, counsel, that that was a redaction as a result of a privileged -- I'm sorry -- a privacy issue.

It is a medication I believe that -- and you and Lindsey and I have had conversations about this with respect to sensitive medications the charging party has taken in the past with some rather private reproduction issues. And I told you and offered to produce things unredacted if we could agree on an "Attorneys Eyes Only" designation and as a result when these documents were produced that discussion and we hadn't come to that agreement.

MR. WHITCOMB: Okay. Well, we can talk about that. I was just trying to understand at least what it was.

Q So looking at the top section, which is the neurological consultation --

A Yes.

Q -- I see it says, "feels hung over from (as read) Elavan."

A Elavil is Amitriptyline, correct.
Q Okay. "But has not been keeping regular hours."
A Correct.
Q So do you remember anything about why she wasn't keeping regular hours?
A This is a typical -- a typical comment made by individuals who are working different shifts.
So, in other words, on the weekends they don't want to spend their whole day doing nothing so they might get up at 8:00 or 9:00 in the morning, and then when they have to go back to work they might sleep, you know, differently. But that's a common thing. On weekends they might do something different.
Q Do you know whether one of the reasons why she wasn't keeping regular hours was that she was trying to work at night and go to school during the days?
A It's not clear by this. I'm not sure. But that certainly could be the case.
Q Okay. Now, I see it says, "Working 3:00 to 11:00 shift work but wants first shift."
A That's what she said.
Q Okay. So she is the one who told you she

wanted to work first shift?

A That's correct.

Q Okay. Do you remember why she told you she wanted to work first shift?

A I don't recall. I don't know if it was because of school hours schedule or what.

Q And is the consultation, neurological consultation, is that a discussion that you have at the beginning of a session with the patient?

A Yeah. As I walk into the room I say what's new? How are things going? How are medications treating you? It's just general banter with some focused neurological questions and sleep questions.

Q And up until this time you hadn't put any restriction on her work shifts, correct?

A I don't believe so.

Q Okay. So going to the bottom of this form then it says under the Impressions and I see number two says, "Shift work sleep disorder." I hadn't seen that before. Can you explain what that is.

A Shift work sleep disorder is a -- typically it's when individuals are tossed around from one shift to another.

But any time you have a situation where a

patient is battling the sun in their 24-hour interval, I will define that as -- well, I don't personally define it but I will list that as playing into the situation.

So it's not just a pristine case of, well, I've got a patient who's awake all day and trying to sleep at night and I'm trying to treat narcolepsy or upper airway resistance syndrome or whatever the cause of their excessive daytime sleepiness is. It's telling me that there's another factor and that is that the individual has to work nights. So it can put a cog in the wheel of sleep efficiency, sleep hygiene.

Q And under No. 4 this hypersomnia, again it says the narcolepsy versus upper airway resistance syndrome?

A Correct.

Q Do I understand you correctly that it was your belief that both of those issues were contributing factors?

A Well, again, we just had one nap that was positive in that study. So I really didn't have a textbook presentation by the patient in that study that says I'm definitely a narcoleptic. I just had one test -- or one nap, excuse me, that was positive for

sleep onset REM.

So because I only had one of those positive, but she was on Elavil and she might have it, I have to keep reminding myself in my notes this might be a narcoleptic. So I listed that in her assessment.

Q So when you say "she might be a narcoleptic," she also might not be a narcoleptic. Is that a fair statement?

A Absolutely.

Q Is it fair to say that you --

A Something's causing her to have excessive daytime sleepiness, whether it's a smelly teddy bear or narcolepsy or upper airway resistance syndrome. Whatever it is she is excessively tired.

So with hypersomnia if I've got a multiple sleep latency test that shows one nap, there is a possibility that could be narcolepsy. But there are a few other causes of that too, including the fact that she was on Amitriptyline.

Q So is it fair to say you were not able to make a definitive diagnosis of narcolepsy?

A That's correct.

Q Okay. And so you couldn't say with medical certainty that she is a narcoleptic; is that true?

A Well, I mean like I said, you can have cases where you don't do any testing. But she's behaving like a narcoleptic. She's got crummy sleep. She's excessively tired. She's got a history of sleep paralysis, hypnagogic hallucinations and cataplexy. I mean, she has a clinical presentation that looks like narcolepsy.

So, you know, even though she wasn't born with it and I can't say, well, this might not be primary narcolepsy, she's had a stroke that can cause narcolepsy. She's got a metabolic disturbance. She's got diabetes. So that could contribute to excessive daytime sleepiness and sort of trigger an underlying propensity for excessive sleepiness associated with a mild form of narcolepsy.

There's enough going on here that I have to list it as a possibility.

Q Right. But you couldn't say with medical certainty that she's a narcoleptic?

A Well, I can state that she clinically has narcolepsy.

Q Based upon?

A Based on clinical history and the fact that she had a single nap sleep onset REM period, and she

was on Amitriptyline which delays REM sleep.

Q Would you agree with me that most people who work at night and go to school during the day have crummy sleep?

MS. LAWS: Objection.

THE WITNESS: I don't know if that's your personal experience. No. I don't know.

BY MR. WHITCOMB:

Q What tests could you have run to determine more definitively whether she had narcolepsy?

A A spinal tap for CFS hypocretin. She was not interested in that.

Q If you had done a spinal tap would you have been able to say with more certainty then whether she had narcolepsy or not?

A Yes. But it wouldn't have changed my treatment, so then that's why I did not pursue that.

The treatment is still stimulant therapy and maintenance of sleep hygiene as best as we can.

Q Okay. So going back at during the neurological consultation, you know, she said she wanted to work first shift. Then I see in your plan your plan was a work slip to work first shift. Do you see that?

A Yes.

Q And so was that work slip prepared at her suggestion that she work first shift?

A That is correct.

Let me clarify that statement. I mean, she wants to work first shift so she says to me, hey, one thing that I could do to feel more alert would be to get better sleep at night, so one way that I can get better sleep at night is I could work first shift.

So she's working with me trying to do everything she can to get on a schedule where she's getting more efficient sleep.

Q But you hadn't recommended that as part of your plan until she suggested that; is that correct?

A Yeah, that's correct.

Q Then it says "Power naps as needed." Can you explain.

A Yeah. That's what we were talking about earlier, the 15-to 20-minute naps spread throughout the day, if that's a possibility, just to provide -- to quench the thrist for sleep that excessive daytime sleepiness causes.

Q By the way, we had looked at some of the notes earlier from 2006 where it indicated that she was

getting eight to ten hours of sleep a night?

A I do recall that, yeah.

Q And I thought there was another note that I was trying to find.

Do you know whether she -- back in 2006 do you know whether she was going to school as well as working?

A I don't recall.

Q Are there certain things that trigger narcolepsy?

A Yeah. That's what I said earlier. You can have a trigger from stroke. You can have a trigger from head injury. I've seen cases associated with Lyme disease. Normal pressure hydrocephalus can give you a narcolepsy-like picture.

But, yeah, there's primary and secondary narcolepsy. There's narcolepsy with cataplexy, narcolepsy without cataplexy.

There's a bunch of different disorders that hover around this diagnosis of narcolepsy.

Q Were you ever able to establish a triggering event for Ms. Stone?

A She did have a stroke, a history of stroke, a basal ganglia stroke. I'm not sure what the time stamp

was on that.

Q If the stroke triggered narcolepsy would the narcolepsy appear, express itself shortly after the stroke, or is there a delay?

A I can't answer that.

Q Also on the plan it says, "Dc Elavil due to next day hypersomnia." Can you explain what that means.

A Yes. She was using Provigil, which is a species-specific drug. When I say that I mean the drug was created for narcolepsy. And so despite using that she was experiencing daytime sleepiness. So I thought, well, maybe the Elavil, which is a sedating tricyclic anti-depressant, perhaps that was contributing to her daytime sleepiness and so I chose to discontinue that crossing my fingers that her headaches would not get worse.

Q I want to skip I believe it's two pages further to the page before you --

A 753.

Q 753, thank you. And also 754.

A Okay.

Q Is this a form that you completed or is any of the writing --

A It's a form I -- Oh, actually, yeah, I did write, "First shift work only due to narcolepsy," and then I signed it.

Q Okay. Is that the only writing on here that is yours?

A That's correct.

Q Okay. And just so I'm clear looking at this page, the top box with the name and the location and the date and the supervisor that's not your handwriting, correct?

A Well, now, I'm noticing here that the date -- the Laura Stone and the date is mine but nothing else is mine.

Q Okay. Thank you.

And then in the next box down --

A That is not my handwriting.

Q That is not your handwriting?

A No, sir.

Q Do you know whose handwriting that is?

A I do not.

Q Okay.

A My staff they do help me fill out forms, so it's possible that they helped out.

Q Then if you look at the next page is the

handwriting where it says, "First shift work only due to narcolepsy," 347.000 is that your handwriting?

A That is my handwriting, yes.

Q And that's your signature?

A Correct.

Q What is 347.000?

A Oh, that is an ICD-9 code for narcolepsy.

Q Are there different levels of narcolepsy?

A Well, like I was saying, there is narcolepsy with cataplexy, narcolepsy without cataplexy.

There's primary narcolepsy, which is something you're basically born with a predisposition for that. And then there's secondary narcolepsy, which is due to head injury, stroke, things like that.

Q And how would you categorize Ms. Stone?

A I'd have to categorize her as secondary because she wasn't apparently born with this problem.

Q And then are there severities of narcolepsy?

A Absolutely, yeah.

Q And do those get graded any way in the medical field?

A I don't personally do that. There may be researchers who do that.

But there are patients who you sneak up

behind them and say boo and they drop to the ground in a cataplectic event.

Good examples in the animal community where you have goats who will do that or dogs that will do that.

So there are severe forms of narcolepsy. The severity can be described as someone who just can't stay awake or the severity could be described as someone who has this cataplectic type of response to high emotion.

Q And do you know whether Ms. Stone had any cataplectic events?

A I believe she did have cataplectic events.

Q Do you know how many?

A I don't remember the details or how many, no.

Again, her primary issue was excessive daytime sleepiness, hypersomnia.

Shall I repeat that?

Q Say that again.

A Yeah. Again, her primary problem was excessive daytime sleepiness and not collapse.

MR. WHITCOMB: Off the record.

(A recess was taken.)

BY MR. WHITCOMB:

Q The next page, which is 726, has a date of service of March 30 --

A Wait. I have the next page. Oh, I'm sorry. Yeah, number 726, March 30th, 2010.

Q Okay. So would that have been the next time you saw Ms. Stone after September 18?

A I believe so.

Q Okay. If you're treating somebody for narcolepsy would it be common to have a span of six months between treatments?

A If they're doing all right, yes.

Q And how would you know if they're doing all right if you don't see them?

A They would call. They would call or email or have some type of communication.

And I never boast and I'm not boasting, but I mean it might be six months before she could make it in again. So I don't know the specifics about this.

Q Okay. If somebody was having issues, though, you would expect them to call and to try to schedule an appointment?

A If they were having emergencies I tell them to go to the emergency room.

If they're having, yeah, significant

problems, yeah, that's the typical drill, they either email or call.

Q Do you know what brought her in on this day?

A This was probably just a routine follow-up.

You know what, I'm noticing this -- If I may just speak?

Q Yes.

A She wanted to try Accutane again and so the question was -- The initial cause of this seizure that she had before was felt to be related to Accutane, an idiosyncratic reaction to medication which sometimes occurs.

So she was hoping to try Accutane again because of acne, pitting acne vulgaris of the face, and so she was hoping to be put on something to stop her from having seizure so that she could try the Accutane again.

That's the gist of this visit. So Lamictal was the cortical stabilizer that I prescribed.

Q And then flip to the next page. It appears to be the same. And then the next entry on page 727 looks like a date of service of November 5th, 2010?

A Yes, sir.

Q And would that have been her next visit after

March 30th?

A It appears, yeah.

Q Do you have patients that you treat for narcolepsy that you see on a more regular basis than Ms. Stone?

A This is a regular, pretty regular basis, yeah. This -- And, again, it could just be in 2010. I don't know what the nature of the practice was, but this might have been the next available.

But, yeah, this would be considered -- you know, two or three times a year would be considered a typical neurological sleep medicine follow-up.

Q Okay.

A I will say that some physicians will make the patient come back, will require the patient to come back every month to get a new prescription.

Psychiatrists and some sleep medicine doctors will do that. I don't do that. That's overkill.

And if I may just say, this box I don't believe is mine. Is this the medication?

MS. LAWS: Yes, that's another instance of that.

THE WITNESS: Thank you.

BY MR. WHITCOMB:

Q Under the neurological follow-up where it says, "No napping with Nuvigil," what does that mean?

A So, Provigil or Modafinil was the first drug in this class that we have that provides an alerting mechanism for narcoleptics. It was replaced by Nuvigil probably just because of the copyright.

But, anyway, so Nuvigil 250 milligrams was felt to be giving her enough daytime alertness so that she did not require the naps.

Q And under the Impressions you indicate that "She has an excellent response to Nuvigil." Do you see the impressions?

A I do see that.

Q Okay. Under the plan it says, "Asa daily." what is that?

A Aspirin daily.

Q Back up at the neurological follow-up I see the Epworth sleepiness score is a two?

A Yes.

Q That's a pretty good score; is that correct?

A It is. Anything below ten is good.

Q Is that a self-reporting type test?

A It is. Well, actually, it's me asking the questions, and her responses dictate the scoring, yeah.

Q Did she do an Epworth sleepiness score when she came to you in July of 2009?

A I'm not sure. I didn't see it in here. But, again, it's just a subjective I'm sleepy or I'm not sleepy-type thing.

When I say are you sleepy, what's the worst sleepiness you've ever been, an eight out of ten, you could extrapolate that and say, well, that's equivalent to maybe 16, 18 out of 24, which is the Epworth. It's all very subjective.

Q If you skip two pages ahead to 728. This looks like a visit of January 18, 2012; is that correct?

A Yes.

Q So is it accurate that she went about 14 months between visits?

A Possibly.

Q And do you know can you tell from this note why she came to you on January 18, 2012?

A She probably needed to come back and see me because she hadn't been to my office for more than a year, and in order for me to prescribe in the State of Ohio I have to see the patient at least once a year. So that was probably a necessary follow-up.

Q There is a note here about the Nuvigil not working and switching to a different medication?

A Correct. Vyvanse is an amphetamine.

Q And her Epworth sleepiness score is a two at this point; is that correct?

A Uh-huh, with medication.

Q Is that a common score for somebody who has narcolepsy?

A That's a common score after treatment. Like potentially you could have two's, four's, anything below ten if you're responding to treatment.

No. But I mean narcoleptics when they present and they're pristine and they're not being treated with anything you would expect their scores to be over ten.

Q But when they are being treated a score of two is common?

A I would consider any score below ten to be effective treatment. You would expect that to be an effective response to medication, a good response to medication.

Q But do most patients get as low as two?

A Sometimes. I don't know about most, but yeah, sometimes we get lucky with our treatment and

patients feel like they're alert.

It's a pretty good dose of Vyvanse, 40 milligrams twice a day.

Q I'll skip the next page. It appears to be the same. That brings us up to 729, which looks a little different form?

A Yeah. So the format changed when I switched over to electronic medical record in June of 2012.

Q Okay. So this appears to be a visit from November 7 of 2012?

A Correct.

Q And would this have been her first visit since January of 2012?

A Could be.

Q Okay. And do you know why she came to see you in November of 2012?

A Again, it could have been related to necessity for a follow-up or I wouldn't prescribe medication for her because of the State of Ohio's regulation, which is a good one.

Q And where it says "CC" what does --

A That's chief complaint.

Q Okay. And her chief complaint it says, "School is killing me. Having to get up so early,

6 a.m."?

A Right.

Q Do you remember anything more about that complaint other than what is written here?

A I don't.

Q And then if you'd flip two pages ahead to 375.

A Yes.

Q This is an Epworth sleepiness score questionnaire, correct?

A Correct.

So she was in on November 7, and this one is dated December 14, 2012.

Q Do you know why she completed this questionnaire roughly a month after her November visit?

A Yeah. This is her -- She was asked by the sleep technician at the time of her sleep study to fill this out. This is a sleep study of 12/14.

Q So is there a reason she had another sleep study on December 14, 2013?

A Yeah. Periodically we'll reassess patients and see how they're changing, see if there's been any difference in the pathology of their sleep or in the architecture of their sleep that would be something

else that might be complicating their treatment.

Q And is this the first time in December of 2012 that you did a study on her since 2009?

A Correct.

Q And you had described the 2009 test as a dirty test?

A Because of the Amitriptyline, right.

Q Do you know in 2012 was this also a dirty test or not?

A She was on medications, yeah. But none of those would affect her dream sleep.

So she was on Lisinopril and she was on Vyvanse during the daytime, melatonin, Tylenol. And the Synvisc is an injection that she had received for her knees.

I have them listed in case the patient has a bad reaction to it and then I'm keen to that.

Q And if you skip to 378, which is that page. There's a handwritten note. Is that your handwriting?

A It is.

Q What does that say?

A It says, "Normal baseline."

Q And then what is under "baseline"?

A "Maintenance of wakefulness test."

Q So can you explain that to me.

A Absolutely.

A maintenance of wakefulness test is performed in an individual typically who is complaining of excessive daytime sleepiness despite treatment. And so the method is that the patient will be placed in a similar setting as the multiple sleep latency test, they'll be placed in a reclined positioning, the lights go out and they're asked to stay awake.

So now in this situation whereas in the multiple sleep latency test we say go ahead and go to sleep.

In a maintenance of wakefulness test basically the lights go out and we say you can sleep, you can stay awake, whatever it is.

But she had this test after receiving the Vyvanse, the stimulant. So the question is, is there objective evidence that after receiving Vyvanse she's still having sleepiness.

Q And what does normal baseline mean?

A Oh, it didn't show evidence -- this particular sleep study did not show evidence of sleep apnea. She had an HI of point eight.

It did not show evidence of periodic limb

movements of sleep. It was not a terribly disruptive sleep study.

The typical cut-off is 85 percent for sleep efficiency. She was at 82.4. So she really wasn't quite as good as we'd like. But in narcoleptics, like I said, we typically see problems with sleep efficiency anyway.

Q Is this a test that would indicate whether or not she was still experiencing -- would indicate whether or not she had narcolepsy?

A No. No, a sleep study is not.

This particular sleep study is not -- or any sleep study is not diagnostic for narcolepsy.

Q So what is the diagnostic for narcolepsy?

And I know I may be asking you to repeat yourself, but --

A Oh, no, I'm fine. You can ask me all day.

Q -- I'm learning.

A So we looked for a clinical history that's consistent and we'd like to see -- you'd like to have the textbook, right? You'd like to have excessive daytime sleepiness, a history of sleep paralysis, a history of hypnagogic hallucinations --

Q I have to ask you to slow down.

A Yeah. So a history of excessive daytime sleepiness or hypersomnia, a history of sleep paralysis, a history of hypnagogic hallucinations and cataplexy, and in order to satisfy those criteria you have to have two of those to satisfy the criteria for a clinical diagnosis of narcolepsy.

Supportive testing for narcolepsy would include spinal tap for CFS hypocretin, HLA-DR2, DQ1.

HLA-DR2, DQ1 those are blood tests that can be performed. I may or may not check those. I really don't find them very useful.

But the primary diagnostic criteria is clinical, and then if you can have a supportive test such as a sleep study with next day MSLT.

You really have to look at that as one unit because you want to interpret what does their sleep look like, what does their nap study look like and do those two together provide support.

Q Okay. And so in Ms. Stone's case what histories -- You gave me several different things you would look for a history of and you said you needed at least two to do. So what was she --

A The clear clinical that I recall in her case would be the sleep paralysis and the excessive daytime

sleepiness. Those would be the two absolutes in her case.

The cataplexy -- I don't recall her specifics. I know she had episodes of slurred speech throughout the day. That can be a form of cataplexy.

Just simple zig-zag walking where you're walking down the hall and you kind of, okay, what was that. Intermittent disequilibrium, things like that can also be minor forms of cataplexy. And I don't remember specifically in her case. But the sleep paralysis and the hypersomnia are clear. And all you need is two of those to --

Q And the hypersomnia is a self-report?

A Well, no. No. In her case with the multiple sleep latency test she came in under that nine-minute mark. She was at 6.9 minutes as I recall. So she satisfies objective criteria for narcolepsy -- I'm sorry -- for excessive daytime sleepiness.

Q Okay. Because that is something that's measured on that test?

A That's correct.

Q Okay. And the sleep paralysis is that something that is also indicated on the test?

A We don't measure that on the test.

Q How is sleep paralysis measured?
A Sleep paralysis is a question that you would simply ask the patient.
Q So that is a self-report?
A That is correct.
Q Now, how does a patient know they have sleep paralysis?
A The clinician has to ask them. And most of the time -- I don't know many patients that will come into the office -- and I've been doing this 20 years. I don't think I've ever had a patient come in and go you know what, I wake up in the middle night and I can't move. It's more so in the questions that we go through to try to work up a sleep disorder that we'll say, well, do you ever wake up in the middle of the night and you can't move anything, and then they'll say, hey, I've had that happen.
Q Is that indicated in the notes we've looked at so far that she reported --
A I don't recall if I have that anywhere in the notes, yeah, that we have here.
Q So how do you remember that she had reported sleep paralysis?
A Because, I mean, she's fairly vivid in my

mind, but I can't show you with what the paperwork that we have in front of us.

Q Okay.

A But I would have no reason to bring that up, you know, outside of the fact that --

Q And, again, excessive daytime sleepiness was on that test that you described as a dirty test, correct?

A The multiple sleep latency testing was dirty because the tricyclic anti-depressant can delay REM sleep. That was the only reason that test was dirty

Q But that's the same test where she had indicated excessive daytime sleepiness?

A Well, I was doing you a favor in saying that because I could go into saying that tricyclic anti-depressants cause a delay in REM sleep and that's another factor that's involved.

That test, like I said, could have showed four or five naps where she went into REM sleep. But it didn't. It showed one.

So the reason why I brought up dirty test -- I don't want a dirty test here. So the reason why I described that as a dirty test was that she was taking a medication that can delay sleep onset REM.

Q Right. But I just want to make sure that's the test we're talking about. There's not a different test?

A The multiple sleep latency test that she had performed after her baseline sleep study showed that she has a mean sleep latency below nine minutes.

Q Okay. I just want to make sure. And that's the test that you have described that she was on medication when you gave her the test?

A That is correct.

Q Okay.

A And that, if anything, would make it less likely for her to have dream sleep.

Q Okay. So if you flip to 373. The page looks like this. The next page.

A Yeah. Thank you.

Q So this appears to be from a study date of December 15, 2012. And I don't know if this is part of the form or not?

A This is a boilerplate sleep study form that is put out by the software makers of the particular Embla system that we use. And this form gets -- this portion of the form gets printed out regardless of whether or not there's anything on it that the

technician or I have added.

Q Would you normally add something under summary statements or is it typical to be blank?

A No. My dictations satisfy that.

Q Okay. And then the next page this is a multiple sleep latency test report from December 15, 2012?

A Correct.

Q And is that handwritten note at the bottom yours?

A Correct.

Q What it looks like there's a dash with a circle and then it says MWT. What is that?

A That's negative multiple -- or excuse -- maintenance of wakefulness test.

Q What does that mean?

A That means that with the Vyvanse on board she was able to stay awake during this test. Her mean sleep latency was over nine minutes.

Q Okay. And then if you flip to page 767, which is I believe one of your electronic notes.

A Okay. Yeah.

Q So this is from December 19th, 2012, correct?

A That's correct.

Q So your impression I want to talk about that.

So when it says, "Normal maintenance of wakefulness testing on Vyvanse 40 milligrams," what does that mean?

A That means that if the patient takes -- and, by the way, I put a line through this at the top. That's not correct. It's a maintenance of wakefulness test. It's not an MSLT, if I can just state that.

Q Okay.

A An MSLT was not prepared. It was a maintenance of wakefulness test. So that's a clerical issue.

But, anyway, so what I'm describing in that situation is that we had the patient take her Vyvanse, which is a stimulant, which is her treatment for excessive daytime sleepiness. She takes that at 6:30, a 40 milligram dosage of Vyvanse, and then we're asking her to try and stay awake.

And so we're saying, well, with the Vyvanse, 40 milligrams, it looks like she's able to maintain a certain degree of wakefulness that satisfies the criteria for this test.

You know, all it's doing is satisfying the criteria of a test that the results of which have been

established by a group of sleep specialists far brighter than me who wrote the textbooks and defined the tests and all these things.

So they're saying to have a normal maintenance of wakefulness test you have to have maintenance of sleep such that you're not falling asleep in less than nine minutes. That's a normal study.

So with 40 milligrams of Vyvanse it looks like she can maintain that absolute criteria. But the problem is in the third period that we're studying her she falls asleep in seven minutes.

So that to me from a clinical standpoint even though it doesn't establish for her that this is an abnormal test, it still tells me that there's an issue still. She is still falling asleep within seven minutes in that nap.

Q So, again, is this where you do five naps?

A This is a four-nap study, yeah.

Q Okay. And so in the third nap she fell asleep within seven minutes?

A That's correct.

Q Is that how I understand this?

A That's correct.

But in this test we're not studying REM onset. We're studying whether or not they fall asleep.

So we're not really ruling in or ruling out specific sleep disorders. This test is defining daytime sleepiness.

Q And when you wrote that care should be taken from 11:00 a.m. and thereafter regarding hypersomnia effects, what does that mean?

A Well, that was in that nap. That specific nap was the 11:00 a.m. nap.

So the fact that she is, you know, she's showing sleepiness there I have to make a comment as a reminder to myself and the physician I'm sending the note to that she did fall asleep in that 11:00 nap. So I have to be mindful of that fact and perhaps adjust her medication such that we're covering that interval of sleepiness.

Even though the test is negative, I still have to be mindful of the fact she does fall asleep in seven minutes at that point in time.

Q Are there concerns about her doing things like driving, then?

A Not necessarily -- Well, there's always a concern about a sleepy individual who's driving. But

these circumstances are relatively extreme because you're putting a patient into a dark room in a reclining position which really doesn't mimic an 11 a.m. driving situation, at least not where I'm from, so yeah.

Q If you flip to the --

A Alaska maybe.

Q If you flip to the next page. This also appears to be a note from December 19, 2012?

A That's when the document was created.

Q Is there a reason why there are two notes from the 19th?

A Two notes from the 19th?

Q The page before was from the 19th.

A Oh, that's when I dictated both.

So, in other words, the study was performed whenever the date was on the study; and then when I get those things on my desk for interpretating, then I go to the computer, I interpret the study, I agree or disagree with what the computer is spitting out, what the technician is saying, and then I make a final dictation on it and put it in the chart.

Q And on this note on page 771 I see there are notes after dash marks?

A Yeah. There are main areas that we have to look at when we're interpreting a sleep study. So we have to look at the breathing. That's comprehensive ventilator monitoring.

We have to look at the sleep stage individually, sleep stages individually. We have to look at how well they maintained efficiency of sleep.

Parasomnia just means did they act out their dreams this time or did they sleepwalk or did they sleep talk or did they grind their teeth. Those are all parasomnias.

Q So she appears -- Or the breathing. Is the breathing normal?

A It is.

Q And then the next -- The sleep stage summary is that normal?

A Yes.

Q And the sleep --

A Well, she had a slight increase of sleep stage shifts, but the absolute sleep stage percentages were normal.

Q And the sleep continuity --

A Continuity.

Q Continuity is normal, correct?

A Well, with the sleep stage shifts being increased that did cause a little disruption of the architecture.

Q What does it mean where you wrote, "Sleep phase is normal"?

A Oh, I'm sorry. Yeah. Let me explain that.

Sleep phase is all of us maintain a certain bedtime to waking time. So if you're a night owl, you would have delayed sleep phase disorder. You've delayed your sleep phase.

So if you always go to bed at midnight or 1:00, you get up at 8:00 or 9:00 or something like that, that's delayed.

If you're advanced sleep phase disorder and you're a morning lark, you know, you like to get to bed at 8:00 or 9:00 and like to get up at 4:00 or 5:00, that you have advanced sleep phase.

Q Okay.

A So in describing her sleep phase she got to bed at a normal -- she got to sleep at a normal time.

Q And then, again, what is parasomnia?

A Para means around. Somnia means sleep. So these are other things that might occur during sleep. Grinding your teeth, talking in your sleep,

sleepwalking, confusional episodes, all those things.

Q And there was no abnormalities?

A No, we did not see the REM behavior disorder this time.

Q And in terms of limb movement monitoring there was no abnormalities?

A That's correct.

Q And she had normal sinus rhythms, correct?

A That's correct.

Q So your impression is she had a normal baseline sleep study. Is that what you would expect to see in somebody who had narcolepsy?

A So "normal" is always a relative term. There is an increase in number of stage shifts, which she does have. But this is an adequate study to proceed with the next day testing.

So it's not diagnostic of sleep apnea. It's not diagnostic of periodic limb movement sleep disorder. It's not diagnostic of a significant parasomnia that would disrupt her sleep and affect the next day study, because what we're looking for is there anything in this baseline study that would cause excessive daytime sleepiness the next day.

Q Okay. And so if we turn -- Well, it says

"Proceed with MSLT."

A Yeah. It's a relative term. It was an MWT.

Q Okay. And do we have that?

A Yeah. That's the page before.

Q Okay.

A Sorry about that.

Q And so that as we already talked about was within the normal range, correct?

A That is correct. Yeah, she fell asleep 12 minutes on the average.

Q And then the next page is the next note I have from you and it's May 7 of 2013. Was the next visit you had after December 19th?

A I would assume so.

Q And do you know why she came to see you on this date?

A I think she had a hospitalization for pulmonary embolism and so part of the discharge was to make sure that she followed up with her sleep doctor.

Q And what is pulmonary embolism?

A Well, I'm not a blood doctor, but what a pulmonary embolism is is a -- it's a blood clot that goes to the heart typically from the leg like a deep

veinous thrombosis.

A clotting issue in the blood creates a blood clot. That blood clot travels through the circulatory system and lodges in the lungs.

People can die from this problem. It causes disruption of -- you know, I'm going to stop there. I'm not an expert.

Q That's okay. You've given me enough.

A That's not fair.

Q Okay. So on this form under "S," which what does the "S" stand for?

A That would be subjective.

Q So explain where it says, "Hypersomnia, sleepy in a.m. Coffee sometimes work. Napping occasionally after coffee for a few hours. Melatonin trial in the past not effective."

Can you explain those comments to me.

A So this is the -- when we sit down to talk I say how are things going? What's new? What's different? Have you had any changes in medication? Have you been in the hospital?

You know, it was obvious she had been because I heard about her hospitalization. So we sit down and I write, "She is status post hospitalization." And so

I basically will take my laptop into the room with the patient and she is telling me this is how I've been.

So I wanted to make it clear in the documentation that her pulmonary embolism was not related to anything that I had given her. A little defensive medicine here. I said this occurred two weeks after stopping Vyvanse. So she already stopped the Vyvanse. So I included that in my document.

I typed in she was diagnosed with pulmonary embolism and right heart failure and she was having some tachycardia, 150 to 160 beats per minute. Anything over 90 is tachycardia. And she continued to smoke. Or she had been smoking at the time of her pulmonary embolism I should say.

Q Is there any significance to the -- next to the hypersomnia it says "napping occasionally after coffee for a few hours." Does that mean anything to you in terms of what her condition was like?

A Well, sleep will overpower anything. It will overpower caffeine. It will overpower pain. It's a very powerful brain type of phenomenon that occurs. So I was just listing.

She had told me that she had stopped the Vyvanse, so she was telling me that she drinks coffee

in the morning and sometimes she can stay awake but it doesn't always work and that sometimes she found herself napping after she had had the coffee to drink.

So she was one of those people that you meet that says, oh, I can drink a 20-ounce coke and go right to sleep.

Q If we flip to the next page, which is 731 and the last page, this looks like this is a visit of July 9th, 2013. Is this the last time you saw Ms. Stone?

A You know what, no. I did see her this summer.

I'll have to find that. I'll ask my staff to print that off.

So I'm assuming this was -- I don't know if this was copied for you guys or for -- that would be before I saw her or not. But I'll make sure you have that most recent note, because I know I saw her this summer.

Q Okay. And then so she is off her medicine, the Vyvanse?

A Yeah. A real tricky situation whenever you get into medical problems that are complicating a patient's physiology, I'll say.

I didn't want to give her a stimulant when she is battling significant tachycardia. She wasn't when she came into my office. Her pulse was 78. But if she's having intermittent or paroxysmal supraventricular tachycardia, then I'm not going to throw an amphetamine at her because I don't want to contribute to another pulmonary embolism.

Q And it indicates that she's taking naps at 10:00 and 3:00. Do you know are those power naps or what type of naps?

A I don't know the duration of those.

Q And then I see the Epworth sleepiness scale says 14. Is that a high or low score?

A That's a high score.

Q And so how does that square with in the section that's labeled "O" it says, "Hypersomnia is mild today"?

A Yes. So she is -- When I say as far as an Epworth goes, I'm not typically asking them how they are today. I'm saying in general how is your function. So the Epworth kind of gives me an in general how you're functioning type of thing.

When she's there under Objective, I'm looking at her. She's not telling me anything.

So under Objective I'm saying, well, she appears a little sleepy today, so my comment would be hypersomnia is mild today.

Q And you said you saw her this summer as well?

A Uh-huh.

Q Do you remember how she was doing this summer?

A Am I allowed to say can we go off the record, because I'll go get that note?

Q Sure.

THE WITNESS: Excuse me.

(A recess was taken.)

THE WITNESS: So here is a copy from the summer.

MS. LAWS: Thank you.

THE WITNESS: July 30th.

MR. WHITCOMB: And if everybody is in agreement, let's just add it to the end of Exhibit 4.

MS. LAWS: Okay.

BY MR. WHITCOMB:

Q Can you tell by looking at this note how she was doing when you saw her this summer?

A Yes. Basically, she just came back in for prescriptions.

And at this point in time her heart problem had -- You know, I didn't list it in here, but her cardiac issues did not recur. She was not having the tachycardia and she was wanting a stimulant again.

Q And in the section labeled A where it says hypersomnia it says, "Idiopathic versus narcolepsy related." Can you explain that.

A Idiopathic means -- It's just abbreviated for idiopathic hypersomnia versus narcolepsy related.

So I have to continue to write that until the last day I see her in her lifetime, my lifetime, whatever, because of the fact that it's just not completely clear by the testing.

Q So when you filled out this form and gave her work restrictions to first shift, did you have particular hours that you thought she should be confined to working or intended that to reflect?

A I do not have that type of approach to that type of letter, no.

First shift to me might be 6:00 in the morning to 2:00 in the afternoon. It might be 9:00 to 5:00. It might be -- You know, first shift doesn't always mean the same thing.

Q So could she have worked from 6:00 in the

morning until 2:00 in the afternoon?

A I don't know.

Q If that was --

A She was very sleepy at 6 a.m. in her maintenance wakefulness test. So it's trial and error.

Q So first shift didn't have any particular hours associated with it to you?

A That's an interesting question, because what I'm saying is that 6 a.m. to 9 a.m. or so that would be considered a first shift schedule.

So if you're asking me if I know what first shift is, then I would say -- I think I'm correct in stating that 6 a.m. to 9 a.m. would be a typical start time for a first shift job, correct.

Q Okay. Was there a particular hour in the day you thought she should be done working by?

A Well, I would assume it would be typically an eight-hour day.

Q Did she tell you what first shift hours were?

A I don't recall if she did. Yeah. I don't know what the shift is that -- the specific shift hours of first shift are in her working situation.

Q Is there any reason she could not have worked a shift that ended at 7 p.m.?

A I have no idea what you're asking.
Q In terms of the work restrictions you've put on her would she have been able to work --
A Well, if it's an eight-hour day, sir, then 11 a.m. to 7 a.m. in my book is typically second shift.
So I don't know what you're asking. Are you asking me if I know what first shift is? Which it's kind of like you asking me to be an HR person.
So I don't know what her shifts were. And I'm telling you that I have no clue what OhioHealth's specific shifts are.
I can tell you a lot of times they vary. If you're a nurse you might work a 12-hour shift. And I don't know. It's usually 7:00 to 7:00 as I recall.
If you are working for a physician's office at OhioHealth you might be asked to come in to first shift at, say, 6 a.m. to get the office prepared and ready. I'm assuming you would be done by 2 p.m. I'm assuming you wouldn't be done by 7 p.m. unless you have some schedule adjustment worked out with that physician where you'd stay on to help them.
Could she work until 7 p.m.? If she was dosed up adequately with a stimulant, perhaps so.
Q No, I'm not asking you to tell me what

OhioHealth's hours are. I was just trying to --

A I'm a neurologist. I don't know. I don't know what the shifts are.

Q I'm trying to understand your restriction.

A Right. Well, first shift in my book, like I said, is a start time between 6:00 and 9:00 I would assume.

Q Okay. Did she ever call you and ask whether she could work an evening shift?

A An evening shift? I don't recall that conversation.

Q Okay.

A If she's asking for first shift, if she asked to occasionally work an evening shift to cover for somebody, I don't recall if she called me to ask me if she could or not.

I mean, that would be -- If she feels like she could pull that off -- that's usually a stretch for someone who has excessive daytime sleepiness, but if she could pull it off, I suppose she could.

Q Is there any reason based upon your treatment of her that she would not have been able to work a regular shift from 11 a.m. to 7 p.m.?

A Well, I know she gets sleepy at 11:00 by her

maintenance of wakefulness test, which would complicate first and second shift. So, yeah, I don't know.

(DEPOSITION EXHIBIT NO. 5 MARKED FOR IDENTIFICATION.)

Q I'm going to show you your declaration. I'm not going to spend a whole lot of time on this.

A Sure.

Q It's been marked as Exhibit 5.

A Sure.

Q Have you seen this document before?

A Yes.

Q And you signed this document?

A I did.

Q Okay. Did you prepare this document or did somebody prepare it for you?

A I did not.

Q What input did you have into the preparation of this document?

A What input did I have? Well, this is all from -- I'm not sure how to answer that. That's from the patient's history and from my understanding of sleep disorders.

Q Did somebody at the EEOC type this up?

A I'm not sure.

Q Did somebody at the EEOC send this to you?

A I just signed it.
Q How did you receive it?
A I'm not sure.
Q Okay. Did you see different versions of this document?
A Not that I recall.
Q Okay. When you got the document did you make any edits to the document before signing it?
A I don't think I did.
Q So under paragraph 10 on page 2 and going over to page 3 it says, "A patient can often tolerate the sleepiness if, with much effort and attention, she makes a strong attempt to stay awake. Eventually, however, it is impossible to combat the recurrent daily sleepiness without treatment."
Do you know where that information came from that was put in here?
A I'm not sure. That's most likely a textbook.
Q Have you provided the EEOC with any information other than your medical notes?
A No.
Q Have you had telephone conversations with the EEOC?
A Yes.

Q And how many conversations do you think you've had?

A I don't recall. It was primarily when can we or when can you schedule a deposition.

Q Okay. Did you have any interview in preparation for your declaration?

MS. LAWS: Objection.

THE WITNESS: I did not have an interview when -- You mean today?

BY MR. WHITCOMB:

Q Yeah.

A We did speak today.

Q No. I'm sorry. In preparation for -- Did you have a conversation with the EEOC that provided information that went into your declaration?

MS. LAWS: Objection.

THE WITNESS: I don't recall, actually.

BY MR. WHITCOMB:

Q And what did you speak today with the EEOC about?

MS. LAWS: Objection.

THE WITNESS: I asked her was there an accident on 315. I said would you like something to drink. That's about it.

BY MR. WHITCOMB:

Q And is the EEOC compensating you for your time?

A No. I should say, I haven't received any payments, but I don't believe I've invoiced either. At least I haven't signed off on anything.

Q Are you charging them for your time?

A Absolutely.

Q Okay. And do you know what the rate of compensation is?

A The rate for any discussion would be $250 an hour. The rate for any deposition is $450 an hour. And that was a reduction in what's typical.

Q Have you had any written correspondence with the EEOC?

A I have not.

Q Has your office?

A They faxed documents to them, which is the same documents that they say they faxed to you.

MR. WHITCOMB: Okay. I appreciate your time today and I have no further questions.

THE WITNESS: Okay.

MR. WHITCOMB: You do have the right to read the transcript when it's prepared to make sure it's

accurate.

THE WITNESS: Okay. I'll read it.

- - -

EXAMINATION

BY MS. LAWS:

Q I'm sorry, Doctor, I know you have a patient waiting.

A No, we're good. I've got ten minutes.

Q I just want to follow up on a few points.

Everything that's in your declaration that's now been marked as Defendant's Exhibit 5 is correct and accurate?

A I believe so, yes.

So I will state that I have listed that the patient has narcolepsy in my statement, and if I was leaving today and somebody put a gun to my head and said what's she got, I still would say -- I mean I would say narcolepsy.

Q And, Dr. Jones, in your medical opinion without the switch to day shift for Ms. Stone back in September 2009 when you were treating her for narcolepsy in the beginning would she have been able to maintain the sleep hygiene that you repeatedly discussed today that would have been needed to manage

her narcolepsy?

A I don't know with 100 percent certainty if that would have worked.

You know, when you're chipping away at different things that cause people to be excessively tired throughout the day you do everything you can to give the patients the best sporting chance possible; and if that's take certain medications, you know, controlled substances, speed basically, to try and stay awake, whether it's changing shifts, these are all things that we look to do to try to make someone as efficient as possible throughout the day.

Q And one of those things that you just mentioned that gave Laura a sporting chance, so to speak, was having her shift switch to day shift hours, correct?

A That's correct.

Ms. LAWS: No additional questions. Thank you for your time and for changing your schedule to accommodate the defense attorney.

MR. WHITCOMB: Thanks.

MS. LAWS: As Mr. Whitcomb already mentioned, our recommendation is that you read and sign the deposition transcript.

THE WITNESS: Sure. I can do that.

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Thereupon, at 12:51 p.m. on Thursday, August 28, 2014, the deposition was concluded.

- - -

CERTIFICATE

STATE OF OHIO :
SS:
COUNTY OF FRANKLIN :

I, DANIEL A. JONES, M.D., do hereby certify that I have read the deposition given on Thursday, August 28, 2014, that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____
DANIEL A. JONES, M.D.

I do hereby certify that the foregoing deposition of DANIEL A. JONES, M.D. was submitted to the witness for reading and signing; that after he had stated to the undersigned Notary Public that he had read and examined his deposition, he signed the same in my presence on the _____ day of _____, 2014.

_____
NOTARY PUBLIC - STATE OF OHIO

My Commission Expires:

_____, _____.

CERTIFICATE

STATE OF OHIO :
SS:
COUNTY OF FRANKLIN :

I, Diane L. Schad, a Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named DANIEL A. JONES, M.D. was sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition then given by him was by me reduced to stenotype in the presence of said witness; that the foregoing is a true and correct transcript of the deposition so given by him; that the deposition was taken at the time and place in the caption specified and was completed without adjournment; and that I am in no way related to or employed by any attorney or party hereto or financially interested in the action; and I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio on this 8th day of September, 2014.

DIANE L. SCHAD
NOTARY PUBLIC - STATE OF OHIO

My Commission Expires: June 1, 2015.

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